

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

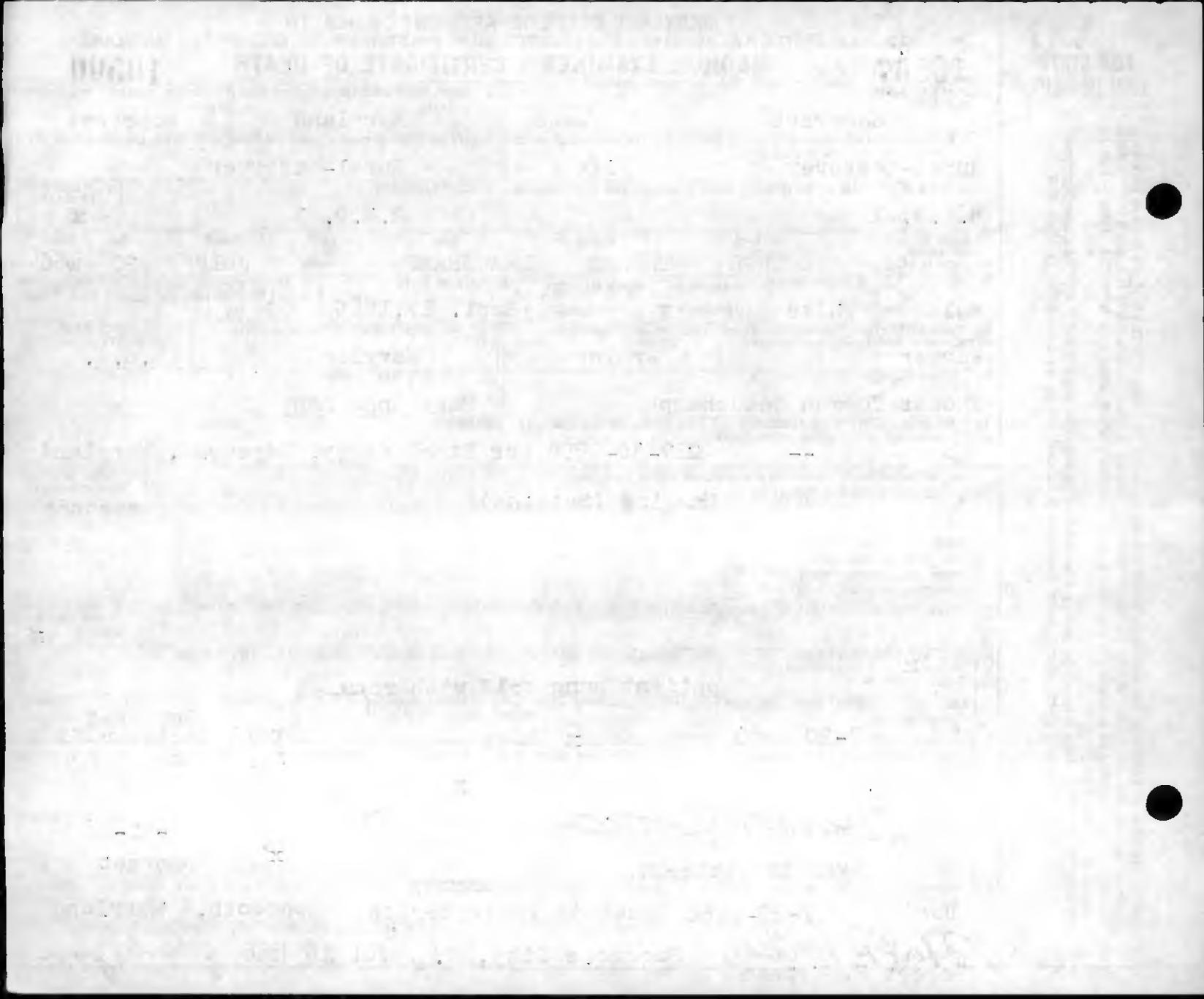
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
10506 CERTIFICATE OF DEATH 10498													
1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 2 Days				b. COUNTY Somerset					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital				e. STREET ADDRESS Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Wm.	Middle Gleason	Last Adkins, Sr.		4. DATE OF DEATH July 8 1966	Month July	Day 8	Year 1966				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1902		9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Stor & Garage			11. BIRTHPLACE (County & State, or foreign country) Marion Station, Md.			12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William Adkins													
14. MOTHER'S MAIDEN NAME Nada Hastings													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No				16. SOCIAL SECURITY NO. 216-40-4418				17. INFORMANT Mrs. Sadie L. Adkins, Same as 2. abcd				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A acute myocardial infarction 4321 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis Chronic myocarditis DUE TO (c) Pentral artery fibrosis Erythema Pentral artery fibrosis Erythema												INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pentral artery fibrosis Erythema												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20b									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1966 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory		20f. (City or town) Crisfield		(County) Md.	(State) Md.		
21. I certify that (I) (this hospital) attended the deceased from July 5, 1966 , to July 8, 1966 , that (I) (we) last saw the deceased alive on July 8, 1966 , and that death occurred at Crisfield, Md. from the causes and on the date stated above.													
22a. SIGNATURE G. C. Coulbourn													
22c. PHYSICIAN'S NAME (Type) G. C. Coulbourn, M.D.				M.O. ATTENDING PHYS. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED JUL 14 1966					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF July 10, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Rehobeth Baptist Cemetery		23d. LOCATION (City, town or county) Rehobeth, Md.				(State)	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.				ADDRESS Bradshaw & Sons, Crisfield, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE			
370				DATE JUL 14 1966									

1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10507								10500			
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westover				c. LENGTH OF STAY IN 1b Life							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE THOMAS BEAUCHAMP		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1885	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Tubman Beauchamp					14. MOTHER'S MAIDEN NAME Mary Anna Long						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NO		17. INFORMANT 217-36-0996		Address Mrs Ethel Gaddy, Edgewood, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging (Suicide) 974X OUE TO Conditions, If any, which gave rise to immediate cause (b), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARILY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) patient hung self with rope											
20c. TIME OF INJURY Month, Day, Year AM p.m. 7-20 1885		20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Rural Westover Md		(County) Somerset		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Everett Sutter</i> EXAMINER'S NAME (Type) Everett Sutter MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Somerset DATE SIGNED 7-22-66											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-23-1966		23c. NAME OF CEMETERY OR CREMATORIUM Rehoboth Presbyterian		23d. LOCATION (City, town or county) Rehoboth, Maryland		(State)			
24. FUNERAL DIRECTOR Robert H. Watson Robert H. Watson ADDRESS Pocomoke City, Md. DATE JUL 26 1966 REGISTRAR'S SIGNATURE <i>Charles Judge</i>											
VR A15ME 3500 4-64											



FOR STATE
HEALTH DEPT.

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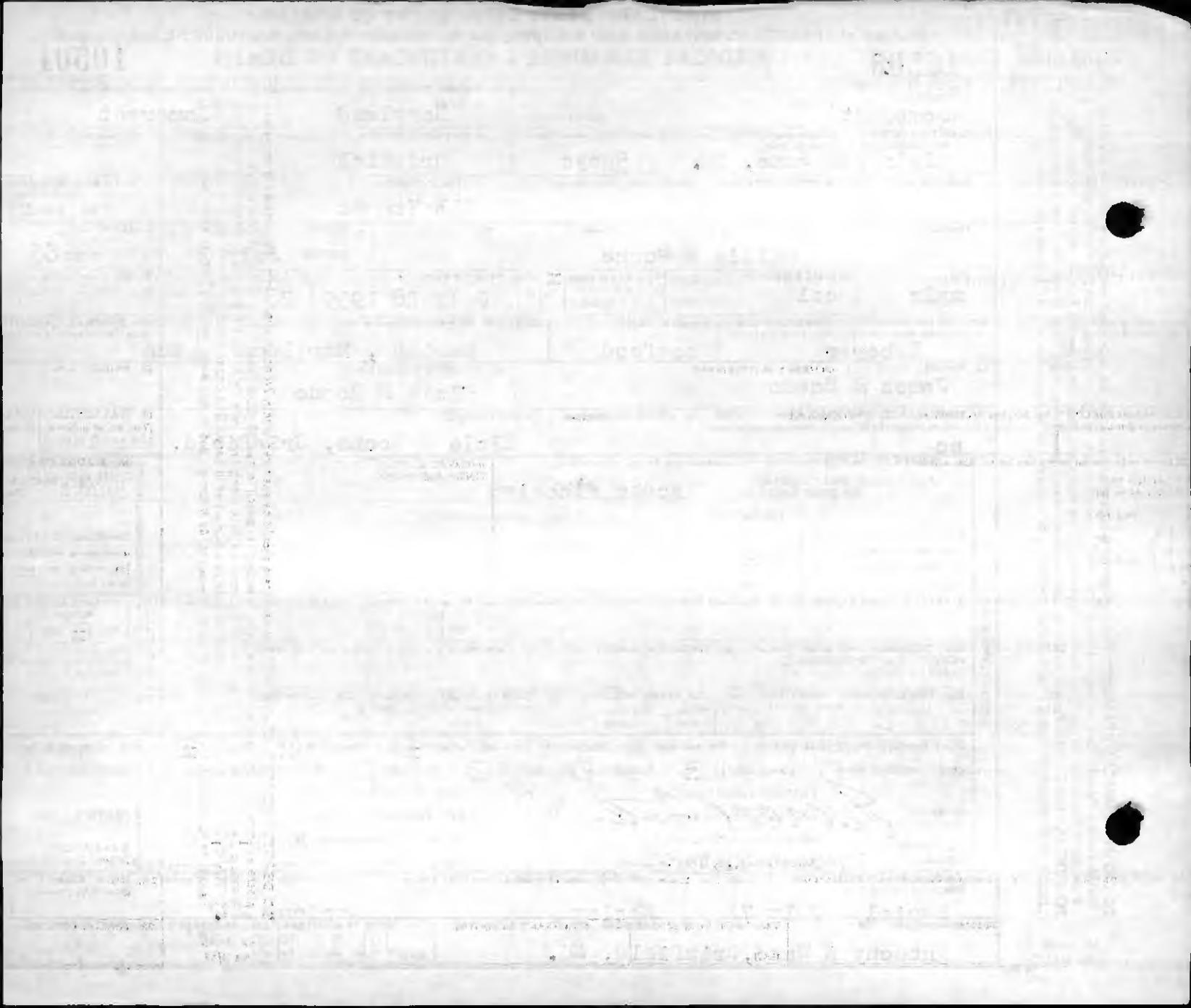
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10508

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10501

1. PLACE OF DEATH a. COUNTY Somerset		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Princess Anne, Md.		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield			
3. NAME OF DECEASED (Type or print)		First Willie M	Middle Boone	Last	4. DATE OF DEATH July 3	Month July	Day 3	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX male		6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28 1939	9. AGE (in years last birthday) 20	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY seafood		11. BIRTHPLACE (State or foreign country) Marion, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James E Boone		14. MOTHER'S MAIDEN NAME Elsie E Boone							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Elsie E Boone, Crisfield, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute alcoholism 3320		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Everett Sutter</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Everett Sutter MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7-7-66	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Wesley		22d. LOCATION (City, town, or county) Marion, Md.		(State)	
23. FUNERAL DIRECTOR Anthony E Ward, Crisfield, Md.				24e. REC'D BY REGISTRAR JUL 11 1966		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



K
10503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										10502	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Somerset					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield						
c. LENGTH OF STAY IN lb 34 years					d. STREET ADDRESS 410 Myrtle Street						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 410 Myrtle Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) NICHOLAS C. EVANS					First	Middle	Last	4. DATE OF DEATH July 20,	Month 1966	Dey Year	
5. SEX Male					6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1902	9. AGE (in years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman					10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Ewell, Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas C. Evans, Sr.										14. MOTHER'S MAIDEN NAME Virgie Evans	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No					16. SOCIAL SECURITY NO. 218-14-2432		17. INFORMANT Mrs. Winnie Evans, Same as 2. abcd				Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH immediate 2 weeks	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) <i>Coronary Thrombosis</i> (c) <i>Coronary Ischemia</i> <i>Arterosclerosis</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/> p.m. 19					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at..... M, from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE <i>Sarah M. Peyton</i>					M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D.					22d. ADDRESS 33 W. Main Street, Crisfield, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 23, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town or county) Crisfield, Md.			(State)		
24 FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.					ADDRESS		25a. REC'D. BY REGISTRAR DATE AUG 5 1966	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

50601

WATER TO ATTACHMENT

616

CEMETERY

base of tree

about

500 ft

200 ft

500 ft

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10510

Item 1d File #350

CERTIFICATE OF DEATH

11870

1. PLACE OF DEATH
a. COUNTY

SOMERSET

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Crisfield

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

337 Broading St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

SOMERSET

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Crisfield

1961

d. STREET ADDRESS

153 S. 4th St.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Donna

Middle
L

Last
Gerald

4. DATE
OF
DEATH

Month
7

Day
31

Year
1966

5. SEX

F

6. COLOR OR RACE

Negro

7. MARRIED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

2/10/65

9. AGE (In years
last birthday)

5 yrs.

10. IF UNDER 1 YEAR

Months
5

IF UNDER 24 HRS.

Days
Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Crisfield Md

12. CITIZEN OF WHAT
COUNTRY?

U.S.

13. FATHER'S NAME

William Gerald

14. MOTHER'S MAIDEN NAME

Jacqueline Douglas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Williams Gerald

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Tropic Myocarditis

INTERVAL BETWEEN
ONSET AND DEATH

3 days

355 X
Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

Basilar Pneumonia

3 days

DUE TO

(c)

Progressive Cerebral Degeneration.

4 mrt.

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 1, 1961, to July 31, 1966, that (I) (we) last
saw the deceased alive on Jul 31 1966, and that death occurred at 6 A.M. from the causes and on the date stated above.

22a. SIGNATURE

A. N. Barr, M.D.

22b. DATE SIGNED
M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 8/4/66

22c. PHYSICIAN'S
NAME (Type)

A. N. BARR, M.D.

22d. ADDRESS

CRISFIELD, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county) (State)
Burial	8/3/66	Asbury	Crisfield Md
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Anthony E. Ward	Crisfield Md	DATE AUG 9 1966	Charles Judge

strange art
and
inventive

10-11-73 - 1973
10-11-73 - 1973
an assistant C.M. R.A.

Item 18 Film 519 3-17 MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

105113

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2MA. Page 5 may be retained for your files.

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105113

1. PLACE OF DEATH

a. COUNTY

Somerset

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Westover

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

none

MARYLAND

c. LENGTH OF STAY IN lb

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

July 31

1966

5. SEX

6. COLOR OR RACE

female

col.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

farm laborer

10b. KIND OF BUSINESS OR INDUSTRY

labor camp

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

1901

9

AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

yrs.

13. FATHER'S NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Tallahassee Florida USA

FANNY CASON Address

Maryland State Police

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

{ (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH
3-5 hours20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type) Everett Sutter IDCHIEF MEDICAL EXAMINER MD ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

8-1-66

Somerset

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

JAMES FUNERAL HOME

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

AUG 8 1966 Charles J. eye



FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Kingston		c. LENGTH OF STAY IN 26 None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 413				d. STREET ADDRESS R.F.D. Lawsonia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle ELDERDICE	Last McDORMAN	4. DATE OF DEATH July 30 1966	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1921	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McDorman		14. MOTHER'S MAIDEN NAME Jane Sterling					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Jane McDorman, same as 2. abcd above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>burned to death in automobile accident</u> <u>8141</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) was in automobile that had an accident and burned		20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30 p.m. 7-30-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) state hiway	
				20f. (City or town) Westover		(County) (State) Somerset Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Everett Sutter</u> EXAMINER'S NAME (Type) Everett Sutter MD							
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22. DATE SIGNED 8-1-66							
Address (Street, city, town, or county) Somerset							
23a. BURIAL, CREMATION, REMOVAL (Specify) Eternal		23b. DATE THEREOF Aug. 3, 1966		23c. NAME OF CEMETERY OR CENERATORY Arlington National Ceme.		23d. LOCATION (City, town or county) Ft. Meyers, Virginia	
24. FUNERAL DIRECTOR		ADDRESS Bradshaw & Sons — Crisfield, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

X

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

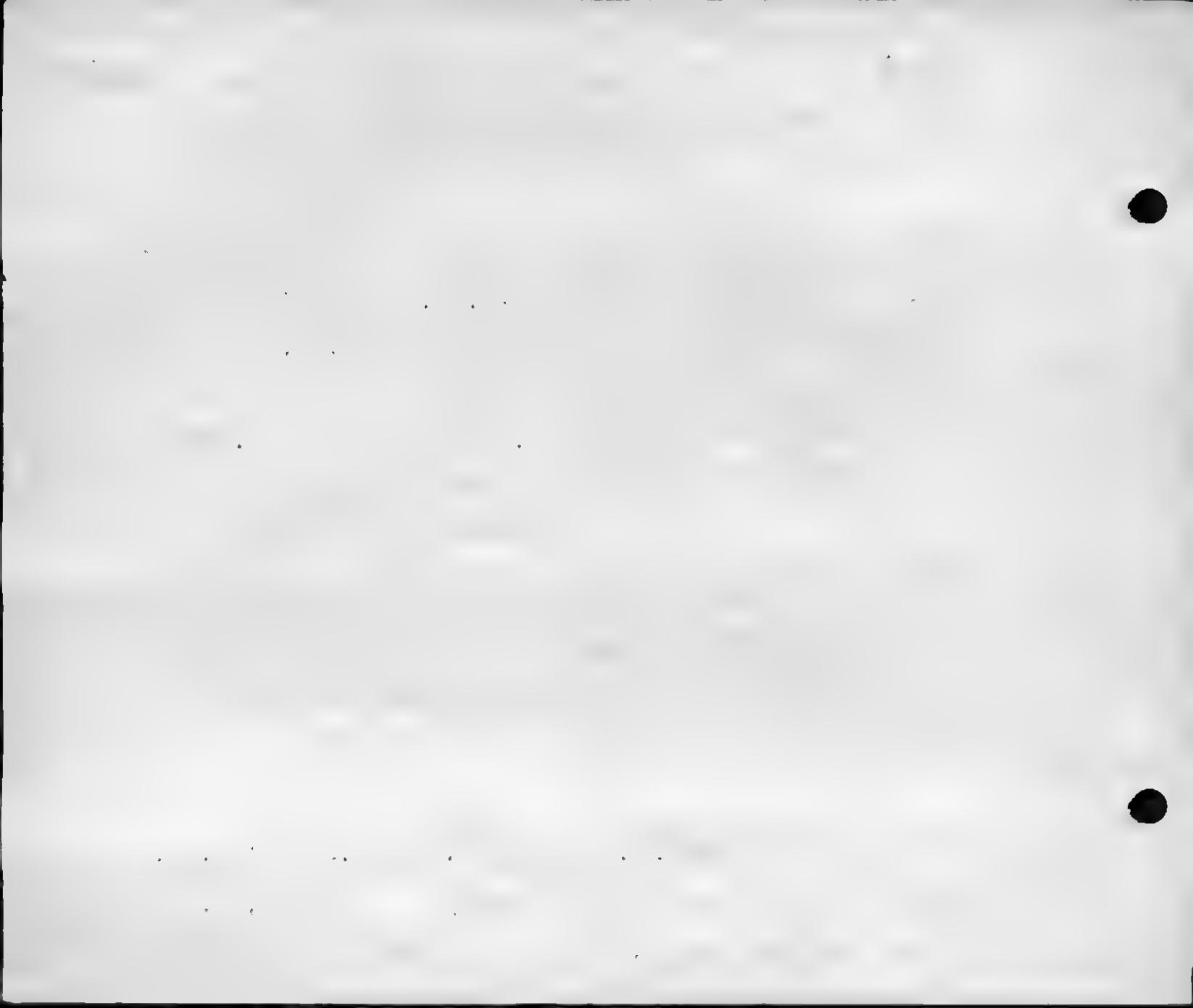
10505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10513

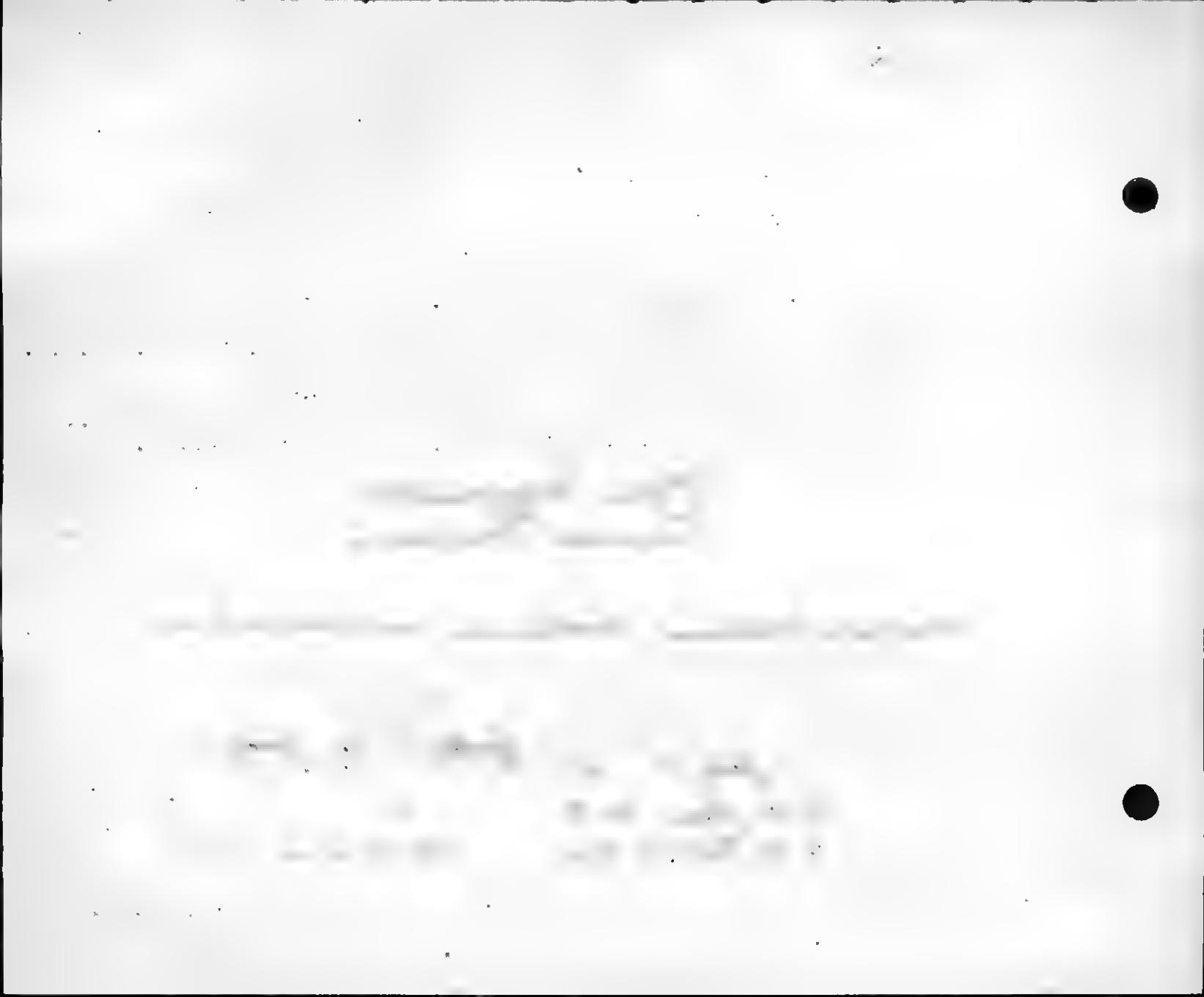
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN lb 45 years			d. STREET ADDRESS Calvary Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Smith Nursing Home			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ELIZABETH FRANCES PARKS			4. DATE OF DEATH July 11, 1966	Month Day Year	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 29, 1889			9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (County & State, or foreign country) Tangier Island, Va.	
13. FATHER'S NAME Charles Murphy			14. MOTHER'S MAIDEN NAME Phoebe Cannon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None			16. SOCIAL SECURITY NO. None 17. INFORMANT Mr. Ralph Parks, Same as 2. abcd Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH 8 hrs.		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			Cerebral Hemorrhage - Gout Arterio-sclerosis		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1948 to July 11, 1966 that (I) (we) last saw the deceased alive on July 11, 1966, and that death occurred at Crisfield, from the causes and on the date stated above					
22a. SIGNATURE C. G. Rawley			M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) C. G. Rawley, M. D.			22d. ADDRESS W. Main St., Crisfield, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Sunnyside Cemetery	23d. LOCATION (City, town or county) Crisfield, Md.	(State)
24 FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.			ADDRESS	25a. REC'D BY REGISTRAR JUL 18 1966	25b. REGISTRAR'S SIGNATURE Judge



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY											
Somerset MARYLAND		Maryland Dorchester											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Crisfield		3 Weeks											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Cambridge											
Smith Nursing Home		807 Locust Street											
3. NAME OF DECEASED (Type or print)		First Maggie	Middle Medora	Last Shores	4. DATE OF DEATH	Month July	Day 17, 1966	Year 19	6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1887	9. AGE (In years last birthday) 78 yrs.	10. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) Secretary, Dorchester Co. U.S.A.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John F. Townsend		14. MOTHER'S MAIDEN NAME Elizabeth Marshall											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-10-8399		17. INFORMANT John N. Shores, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tropic Myocarditis Terminal Pneumonia 24 hr 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) Tropic Myocarditis Terminal Pneumonia 24 hr 3 days	DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple Abdominal Adhesions and Operation for same													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from July 7, 1966, to July 17, 1966, that (II) (we) last saw the deceased alive on July 17, 1966, and that death occurred at 30 M, from the causes and on the date stated above.		22b. DATE SIGNED 7/19/66											
22a. SIGNATURE A. N. Barr, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22d. ADDRESS CRISFIELD, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 19, 1966		23c. NAME OF CEMETERY OR CREMATORIAL PARK Dorchester Memorial Park, Cambridge, Md.		23d. LOCATION (City, town or county) Cambridge, Md.		(State)					
24. FUNERAL DIRECTOR R. Kenneth A. Thomas, Cambridge, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 1/65													



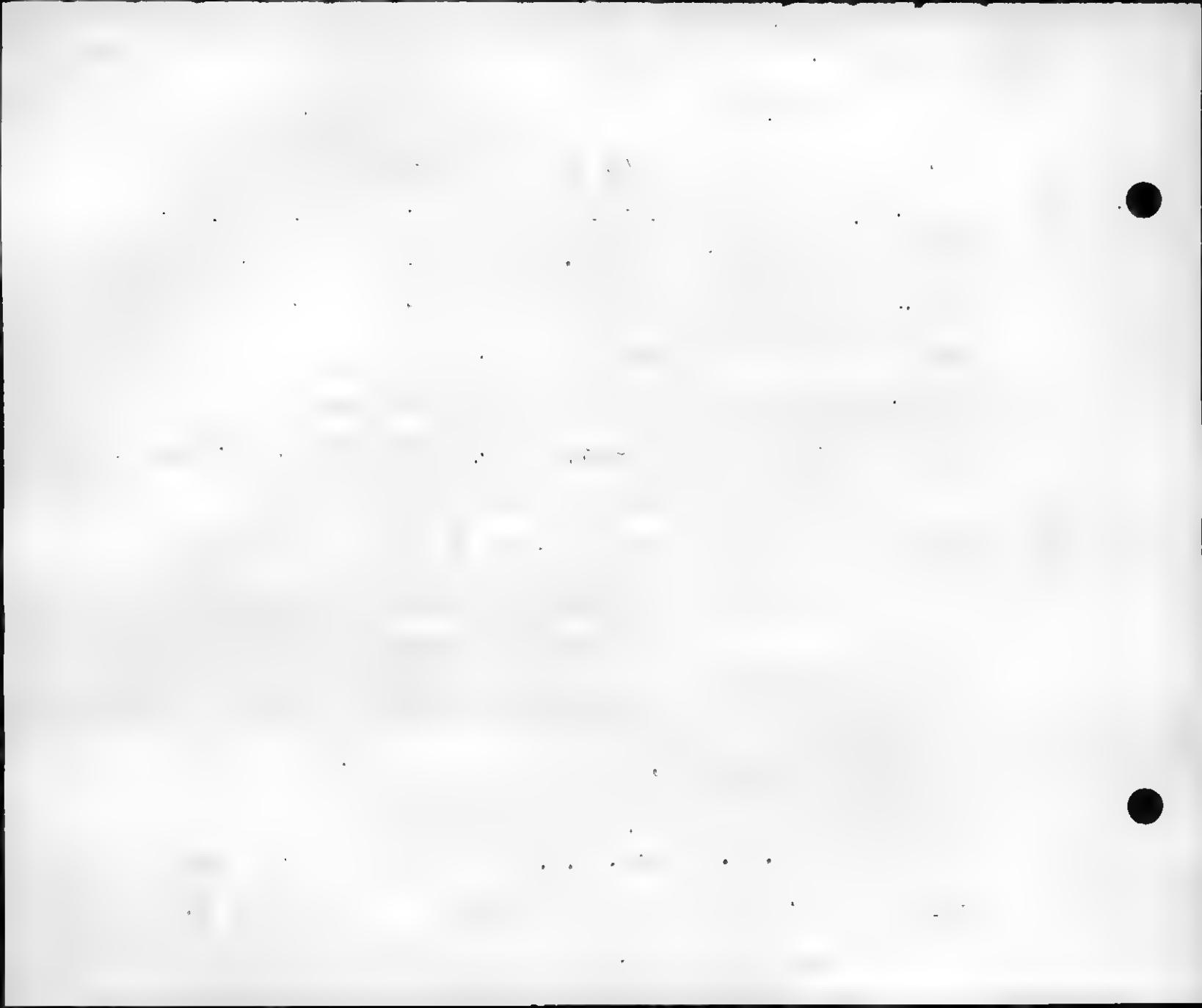
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

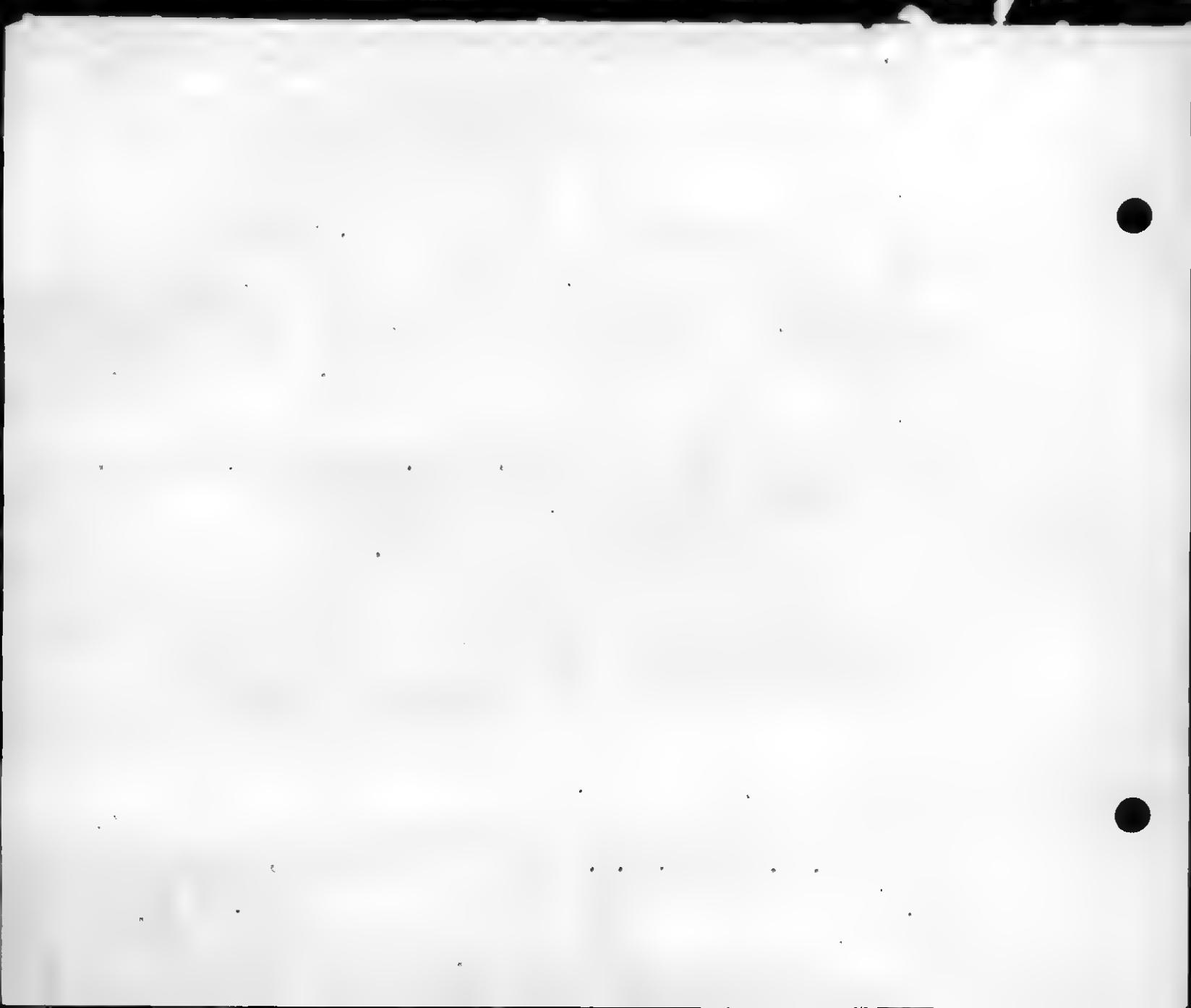
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b All Life				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Lydia	Middle B.	Last Sterling	4. DATE OF DEATH Month July Day 25 Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 20, 1893	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Landon		14. MOTHER'S MAIDEN NAME Virginia Evans		Address R. T. Sterling, 211 S. Somerset, Crisfield		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 217-01-4614		17. INFORMANT INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Maxine Cardine Buxton Hypertension & Cong. in Aorta Pulmonary edema				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) Crisfield	(County) Maryland	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from July 20, 1966, and saw the deceased alive on July 20, 1966, and that death occurred at 12:00 M.		to 19, 1966, that (I) (we) last from the causes and on the date stated above.				
22a. SIGNATURE S. M. Peyton, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED AUG 1 1966
22c. PHYSICIAN'S NAME (Type) S. M. Peyton, M.D.		22d. ADDRESS Crisfield, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	23d. LOCATION (City, town or county) (State) Crisfield, Md.		
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE							
Somerset				Maryland							
MARYLAND				b. COUNTY							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b							
Crisfield				31 Days							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
McCready Memorial Hospital				Rt # 1, Lawsonia							
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Melissa				C	Sterling		July	3	1966		
5. SEX				6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	FUNDER 1 YEAR	FUNDER 24 HRS.	
Female				White	WIDOWED	<input checked="" type="checkbox"/>	Divorced	<input type="checkbox"/>	Aug. 26, 1873	92 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
housewife								Somerset Co., Maryland			
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?							
George Wilson				U.S.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT			
(If yes give war or dates of service)								Herman Sterling, Crisfield, Md.			
Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				1172 Hepatic Failure							
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				1172 Due to ? Coronary Artery Disease							
DUE TO (b) Cause (a), stating the underlying cause last.				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH							
Deferior Aneuristic Heart Disease											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not White <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/>				20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
Raped - 4/6/66 by 2 negro boys											
21. I certify that (I) (this hospital) attended the deceased from May 22, 1966, to July 3, 1966, that (I) (we) last saw the deceased alive on July 3, 1966, and that death occurred at 8:00 P.M. from the causes and on the date stated above.				22d. DATE SIGNED 7/4/66							
22a. SIGNATURE S. M. Peyton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) S. M. Peyton, M.D.				22d. ADDRESS Crisfield, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation July 6, 1966				23b. DATE THEREOF July 6, 1966							
23c. NAME OF CEMETERY OR CREMATORIAL Asbury				23d. LOCATION (City, town or county) Crisfield, Md. (State)							
24. FUNERAL DIRECTOR John Denman				25a. REC'D BY REGISTRAR Crisfield, Md.							
ADDRESS				25b. REGISTRAR'S SIGNATURE Charles Judge							
DATE JUL 8 1966											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10509

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>SOMERSET</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		d. STREET ADDRESS <u>ASBURY SECTION</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION <u>SMITH CARE Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
II. NAME OF DECEASED (Type or print) <u>WILSON B</u>		First <u>W</u>	Middle <u>I</u>	Last <u>STERLING</u>	4. DATE OF DEATH <u>July 8 1966</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>NOV 2 - 1892</u>	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Leaf Prod.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>ANDREW</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W.I. 218-07-5438</u>		17. INFORMANT <u>Joseph C Sterling Crisfield Md</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, prostate</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinsonism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Crisfield</u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>C. K. Crowley</u> M.D.					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-66</u>		22c. NAME OF CEMETERY, OR CREMATORIAL ADDRESS <u>Asbury Cemetery</u>	
22d. REC'D BY REGISTRAR DATE JUL 15 1966		22e. LOCATION (City, town, or county) <u>Crisfield</u> (State) <u>Md.</u>			
22f. FUNERAL DIRECTOR'S SIGNATURE <u>Levister</u>		22g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

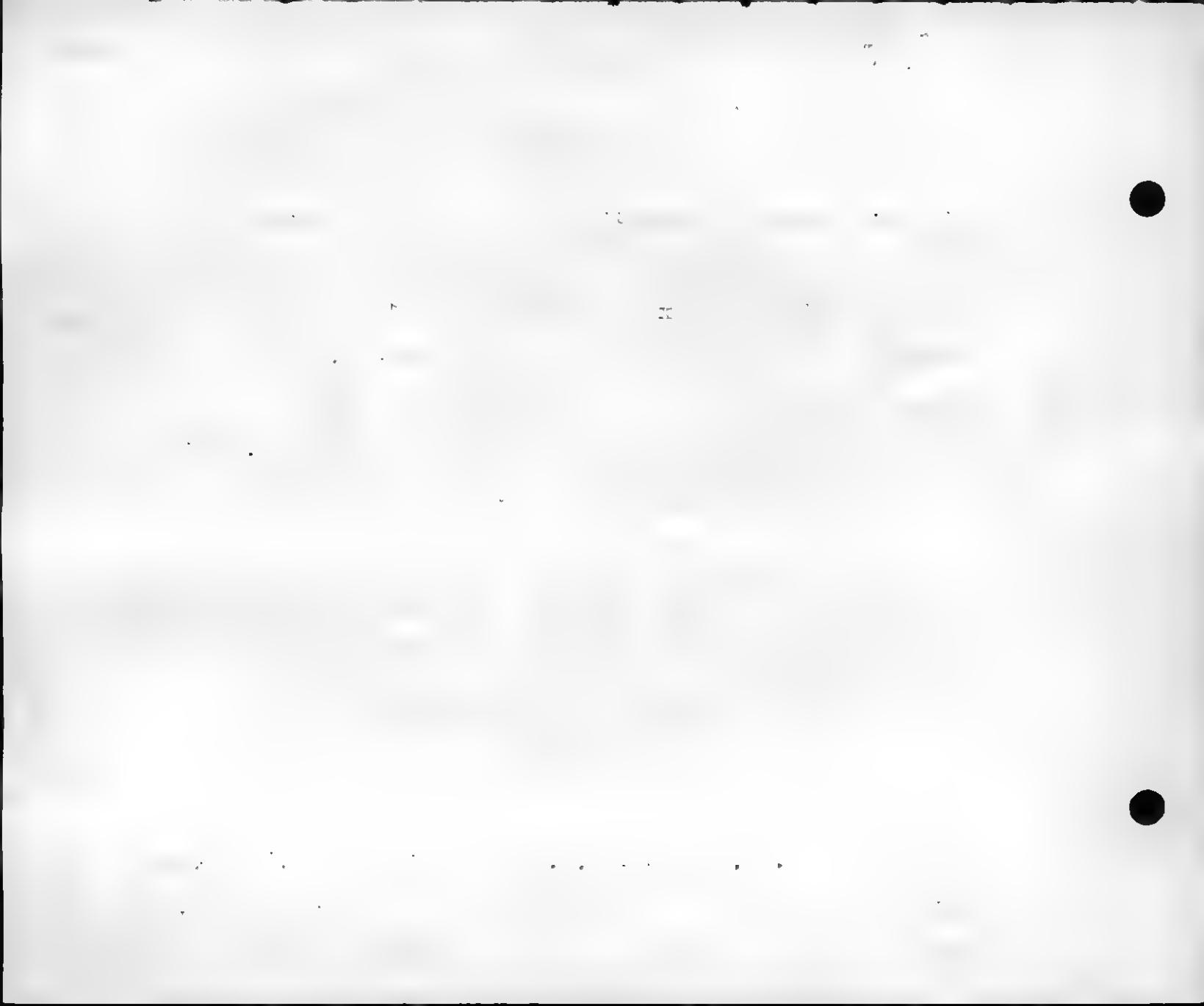
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												1966					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY			Somerset			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			a. STATE Maryland			b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Crisfield			c. LENGTH OF STAY IN 1b 10 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Crisfield					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			McCready Memorial Hospital						d. STREET ADDRESS			718 Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle		Last			4. DATE OF DEATH	Month	Day	Year					
Female			Matilda			White			July	28	19	66					
5. SEX			6. COLOR OR RACE	7. MARRIED	<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	Months	Days	Hours	Min.		
Female			White					1883	83	yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
						Home			Dorchester Co., Md.			USA					
13. FATHER'S NAME			Thomas H. Travers			14. MOTHER'S MAIDEN NAME			Catherine Lewis								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			None			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No						220-26-7724			Katie Turack, Same as 2. abcd								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]															INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Hemiplegia - C.V. accident -									11		
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			DUE TO			Cardinal Thrombosis									year		
			(b)			Atherosclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
19																	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on July 28 1966, and that death occurred at 3 M, from the causes and on the date stated above.																	
22a. SIGNATURE			S. M. Peyton, M.D.						22b. DATE SIGNED								
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS			Crisfield, Maryland								
Burial			7/31/66			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county) (State)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			Crisfield Cemetery			Crisfield, Md.								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Bradshaw & Sons, Crisfield, Md.									DATE AUG 3 1966			Charles J. Bradshaw					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and No. 3 any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield									
c. LENGTH OF STAY IN 1b 19-1				d. STREET ADDRESS 205 Main St. Extd.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Rosalie	Middle	Last White	4. DATE OF DEATH Month July	Day 3	Year 1966						
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/1915	9. AGE (In years last birthday) 50 yrs.	10. KIND OF BUSINESS OR INDUSTRY SEAFood		11. BIRTHPLACE (County & State, or foreign country) Crisfield Md.	12. CITIZEN OF WHAT COUNTRY? U.S.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laberer			10b. INFORMANT Waverly Smith			14. MOTHER'S MAIDEN NAME Rosie Jones			Address Crisfield				
13. FATHER'S NAME Sidney White			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.			17. INTERVAL BETWEEN ONSET AND DEATH 7 days				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Type Myocarditis DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Glomerulonephritis			DUE TO (b) DUE TO (c)			20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
21. I certify that (I) (this hospital) attended the deceased from 6/20 , 19 66 , to 7-3 , 19 66 , that (I) (we) last saw the deceased alive on 7-3-66 19 66 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			22a. SIGNATURE A. N. Barr, M.D.			22b. DATE SIGNED 7/4/66							
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M.D.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS Crisfield, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/8/66			23c. NAME OF CEMETERY OR CREMATORIAL Hisbury			23d. LOCATION (City, town or county) (State) Crisfield MD				
24. FUNERAL DIRECTOR Anthony E. Abad Crisfield Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE JUL 11 1966			25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 20M 1/65													

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10512

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the certificate. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE	
Somerset MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	Somerset	
Crisfield	Lifetime		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
DOA McCready Memorial Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CLAUDETTE	Middle WHITTAKER	Last
4. DATE OF DEATH	Month July	Dey 1	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 25, 1964
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? USA		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Andrew S. Whittaker		Rebecca Cannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Andrew S. Whittaker, Crisfield, Md.	
Strangulation		INTERVAL BETWEEN ONSET AND DEATH Minutes	
9360			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		OUE TO (b)	
		OUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
Accidental strangulation while at play.			
20c. TIME OF INJURY Month, Day, Year Hour XX 3 p.m. 7/1/1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Crisfield Som. Md.	
Home			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>C.G. Rawley.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) C. G. Rawley		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Crisfield, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/66	
23c. NAME OF CEMETERY OR CREMATORIAL Wesley Cemetery		23d. LOCATION (City, town or county) (State) Marion Som. Md.	
24. FUNERAL DIRECTOR Anthony E. Ward		ADDRESS Crisfield, Md.	
25a. REC'D BY REGISTRAR DATE JUL 11 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

